DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 12/7/11

PRINTED: 11/07/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445298	A. BUILDING _____ B. WING _____	11/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF ATHENS	1234 FRYE STREET, PO BOX 786 ATHENS, TN 37371

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS During complaint investigation numbers 28771, 28886, and 28227, conducted on October 31, 2011, through November 2, 2011, at Life Care Center of Athens, no deficiencies were cited under 42 CFR Part 483.13, Requirements for Long Term Care.	F 000		
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview the facility failed to resolve grievances for one resident (#8) of twenty-seven residents reviewed. The findings included: Resident #8 was admitted to the facility on July 1, 2010, with diagnoses of Multiple Sclerosis, Paraplegia, Osteoporosis, and Chronic Constipation. Medical record review of the Minimum Data Set (MDS) dated August 28, 2011, revealed the resident was unable to bear weight, and required moderate assistance with transfers and activities of daily living and was independent in daily decision making. Interview with the resident on October 31, 2011,	F 166	1. Dentist appointment was scheduled for resident #8 on November 16, 2011 to resolve any issues with dental bridge secondary to incident. 2. All residents have the potential to be affected. Social Services Director and/or Assistant Executive Director will conduct a 100% audit of all grievances reported during the past year to ensure that prompt efforts were made by the facility to resolve grievances. Any grievances found unresolved will be followed-up on and resolved promptly. 3. Social Services Director and/or Executive Director will inservice staff on the facility's policy and procedures for managing grievances. Social Services Director and/or Staff Development Coordinator will educate new staff on orientation of the facility's policy and procedures for managing grievances. Executive Director will continue to review all concern and comment forms to ensure grievances are being resolved promptly. Social Services Director and/or Assistant Executive Director	12/2/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Executive Director	11/16/2011

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 166	Continued From page 1 at 8:59 a.m., in the residents room revealed, the resident stated on January 28, 2011, in the facility shower room, the resident was accidentally struck in the face with the arm of a Hoyer Lift, (a mechanical lift used to transfer residents) chipping the resident's dental bridge. Continued interview revealed the resident had reported the incident to the facility and complained it had not been resolved. Medical record review of the facility Concern and Comment Form, dated January 31, 2011, revealed, "...stated that CNA (Certified Nurse Aide) hit...in mouth with Hoyer lift and chipped...bridge." Medical record review of the Social Services Progress Notes dated January 31, 2011, revealed, "...would review the schedule and check who was working on that particular day and re-educate on operating lift." Review of facility Policy, Abuse Prevention Managing Incidents and Falls revealed, "...Falls & (and) incident management policies include the following ...floor nurse completes initial incident report. The initial incident documentation must first describe who, what, where, and when regarding the fall/ incident in the medical record...an accident incident report wil be complete whenever an accident or incident happens, no matter how minor or major the incident/accident may be." Interview with the Director of Nursing (DON) on November 2, 2011, at 11:00 a.m., in the conference room, confirmed the incident had not been documented in the medical record and no	F 166	will conduct audits of all resident grievances monthly times three months to ensure that prompt efforts were made by the facility to resolve grievances. 4. Audit results will be given to the Executive Director and will be reviewed in the monthly performance improvement meeting for three months or until 100% compliance is achieved.	

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F 166	Continued From page 2 investigation for the resident complaint had been completed.	F 166		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure the Minimum Data Set	F 278	1. Resident #5 had MDS attestation on the 10/11/2011 quarterly assessment to include the fall, which occurred on 9/5/2011. MDS Coordinator completed this attestation on 11/4/2011. 2. All residents have the potential to be affected. MDS Coordinator and/or Assistant Director of Nursing will conduct a 100% audit of all resident MDS assessments for the last 90 days to ensure that that the assessments are coded accurately for falls. Modifications will be completed on any assessments found inaccurately coded for falls. 3. Director of Nursing and/or Assistant Director of Nursing will inservice MDS coordinators on the new process which includes the Director of Nursing printing a falls report monthly and providing a copy to the MDS coordinators to ensure that falls are recorded accurately. MDS coordinators will continue to review the medical records for the documentation of falls and continue to attend the events meeting where resident falls are reviewed. Assistant Director of Nursing will audit 10% of all resident MDS assessments for accurate coding for falls monthly times three months.	12/2/2011

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F 278	Continued From page 3 (MDS) was accurate for one resident (#5) of twenty-seven residents reviewed. The findings included: Resident #5 was admitted to the facility on August 28, 2009, with diagnoses including Right Hemiparesis, Stroke, and Dementia. Medical record review of the MDS dated October 11, 2011, revealed the resident had no falls since the prior assessment dated July 14, 2011. Medical record review of a Nurses' Note dated September 5, 2011, at 12:12 a.m., revealed, "...resident discovered on floor of room..." Medical record review of the facility documentation dated September 4, 2011, revealed, "...res was observed laying on back on parameter (fall mattress..."). Interview on November 1, 2011, at 10:00 a.m., with Registered Nurse (RN) #1, in the care plan office, confirmed the MDS dated October 11, 2011, did not reflect the resident's fall on September 5, 2011, and confirmed the MDS was not accurate.	F 278	4. Audit results will be given to the Director of Nursing and will be reviewed in the monthly performance improvement meeting for three months or until 100% compliance is achieved.	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 425	1. No adverse reactions affecting residents #9 and #12 were identified. Nurses who were responsible for the administration of the medications for residents #9 and #12 will be educated on the facility's policy and procedures for ensuring accurate acquiring, receiving, dispensing, and administering of pharmaceutical services.	12/2/2011

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F 425	Continued From page 4 A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to provide pharmaceutical services in a timely manner for two residents (#9 and #12) of twenty-seven residents reviewed. The findings included: Resident #9 was admitted to the facility on August 27, 2009 with diagnosis of H.I.V. (Human Immunodeficiency Virus). Medical record review of the Medication Administration Record (MAR) for July and August of 2011, revealed Truvada (a medication to treat H.I.V), was not administered on July 29, 30, 31, and August 1, 2011. Fuzeon (a medication to treat H.I.V.), was not administered on July 17, 18, 2011, and Prevista (a medication to treat H.I.V.), was not administered on August 9, 2011. Interview with Licensed Practical Nurse #1,(the	F 425	2. All residents receiving pharmaceutical services have the potential to be affected. Director of Nursing conducted a 100% audit on 11/4/2011 of all resident medication administration records to ensure that accurate acquiring, receiving, dispensing, and administering of pharmaceutical services were provided. 3. Staff Development Coordinator and/or Director of Nursing will inservice nurses and new nurses on orientation of the facility's policy and procedures for ensuring accurate acquiring, receiving, dispensing, and administering of pharmaceutical services. Unit managers will conduct audits of all resident medication administration records weekly times three months to ensure that accurate acquiring, receiving, dispensing, and administering of pharmaceutical services were delivered. 4. Audit results will be given to the Director of Nursing and will be reviewed in the monthly performance improvement meeting for three months or until 100% compliance is achieved.	

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F 425	Continued From page 5 nurse responsible for the administration of the medications) on November 1, 2011, at 3:55 p.m., in the east wing nursing station, confirmed the medications were not administered because they were unavailable from the facility pharmacy. Resident # 12 was admitted to the facility on January 10, 2010, with diagnoses including Pain, Osteoarthritis, and Chronic Obstructive Pulmonary Disease. Medical record review of the Minimum Data Set (MDS) dated February 19, 2011, revealed the resident was on a scheduled pain medication regimen. Medical record review of a Physician Telephone Order dated August 22, 2011, at 9:00 p.m., revealed, "...omit 8 p.m. dose of Hydrocodone/Apap 5/500 mg (pain medication) pending availability from pharmacy..." Medical record review of the Medication Record dated August 2011, revealed the resident did not receive Hydrocodone/Acetaminophen 5-500 tablet on August 22, 2011, at 8:00 p.m. Interview on November 1, 2011, at 3:30 p.m., with Registered Nurse #2, in the West Wing Nurses' Station, confirmed the medication was not available and the facility failed to acquire the medication in a timely manner.	F 425		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional	F 514	1. Dentist appointment was scheduled for resident #8 on November 16, 2011 to resolve any issues with dental bridge secondary to incident.	12/2/2011

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F 514	Continued From page 6 standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to maintain complete and accurate medical records on one resident (#8) of twenty- seven residents reviewed. The findings included: Resident #8 was admitted to the facility on July 1, 2010, with diagnoses of Multiple Sclerosis, Paraplegia, Osteoporosis, and Chronic Constipation. Interview with the resident on October 31, 2011, at 6:59 a.m., in the resident's room, revealed the resident reported was accidentally struck in the face with a Hoyer Lift (a mechanical lift used to transfer residents) on January 28, 2011. Medical record review of the Physicians Progress Notes, Nursing Notes, Certified Nursing Aide Notes, and Social Service Notes revealed no documentation of the incident. Review of facility Policy, Abuse Prevention	F 514	2. All residents have the potential to be affected. Staff Development Coordinator will inservice staff on the facility's policy and procedures for managing incidents. Executive Director will send out a letter to residents and/or their legal/appointed representatives on how to report incidents based on the facility's incident management policy and procedures. 3. Staff Development Coordinator will inservice new staff on orientation of the facility's policy and procedures for managing incidents. Marketing Director and/or Admissions Coordinator will educate residents and/or their legal/appointed representative on admission on how to report incidents based on the facility's incident management policy and procedures. Director of Nursing and/or Assistant Director of Nursing will conduct audits of all new employee orientation records monthly times three months to ensure that new staff are being educated on the facility's policy and procedures for managing incidents. Marketing Director and/or Assistant Executive Director will conduct audits of all new resident admission records monthly times three months to ensure that residents and/or their legal/appointed representatives are being educated on how to report incidents based on the facility's incident management policy and procedures.	

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F 514	Continued From page 7 Managing Incidents and Falls revealed, "...Falls & (and) incident management policies include the following...floor nurse completes initial incident report. The initial incident documentation must first describe who, what, where, and when regarding the fall/ incident in the medical record..." Interview with the Director of Nursing (DON), on November 2, 2011, at 11:00 a.m., in the conference room, confirmed the incident had not been documented in the medical record and the record was not complete and accurate . .	F 514	4. Audit results will be given to the Executive Director and will be reviewed in the monthly performance improvement meeting for three months or until 100% compliance is achieved.	